

State of Connecticut Medical Discount Plan (MDP) License Instructions

Effective January 1, 2006, Public Act 05-237 requires all Medical Discount Plans ("MDP") offering services in the State of Connecticut to be licensed. The State of Connecticut Insurance Department ("Department") is charged with licensing MDPs. If you have any questions about your responsibility to be licensed, please refer to CT Public Act 05-237 which can be accessed on the Connecticut General Assembly website at <http://www.cga.ct.gov/2005/act/Pa/2005PA-00237-R00HB-06619-PA.htm>

Instructions:

To assure that a MDP license be issued prior to offering services in Connecticut, the Department suggests that applications be submitted at least two months in advance. If your Plan meets the guidelines for licensure, an invoice for the license fee of \$500 will be forwarded to you. This invoice must be paid prior to the license effective date.

The application must be filled out, completed, and signed by an officer or authorized representative of the MPD entity certifying that all information provided is true and accurate.

Submit your application and attachments to:

State of Connecticut Insurance Department
Life and Health Division
P O Box 816
Hartford, CT 06142-0816

Hand delivery or Overnight delivery address ONLY:

153 Market Street, 7th floor
Hartford, CT 06103

DO NOT SUBMIT THE LICENSE FEE WITH THIS APPLICATION. You will be billed.



State of Connecticut Medical Discount Plan (MDP) License Application

☐ NEW

☐ RENEWAL

FOR CALENDAR YEAR _____

Name of MDP: _____

MDP CT License Number (complete for license renewals only) _____

MDP Tax Identification Number (TIN/FEIN) _____

MDP Business Address: _____

MDP Mailing Address (if different): _____

MDP Phone Number: _____

Contact Information (used by the Department for all future correspondence):

Name: _____ Title: _____

Mailing Address: _____

Phone number: _____ FAX number: _____

E-mail address: _____



State of Connecticut Medical Discount Plan (MDP) License Application

Name and description of controlling company or organization: _____

Controlling company's or organization's contact name: _____

Business Address: _____

Mailing Address (if different): _____

Name of related or predecessor controlling company or organization:

Address: _____

Explain current relationship with related or predecessor controlling company:

Has any suspension, sanction or disciplinary action been taken against the MDP in Connecticut or any other state?

☐ No

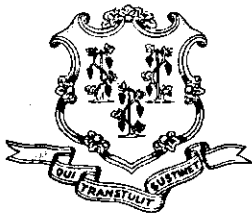
☐ Yes If yes, explain: _____

Has any suspension, sanction or disciplinary action been taken against the controlling company or organization in Connecticut or any other state?

☐ No

☐ Yes If yes, explain: _____

How many total enrollees are served by the MDP: Nationwide: _____ in CT: _____



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List all Provider Networks with whom MDP has contracts or agreements to provide discounted health care services to Connecticut enrollees:

Indicate types of discount services that the MDP provides to Connecticut enrollees:

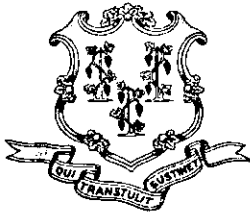
- ☐ Physician Medical services
- ☐ Hospital services
- ☐ Laboratory services
- ☐ Radiology services
- ☐ Prescription Drugs
- ☐ Dental Services
- ☐ Other – List types of services



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PLEASE SUBMIT THE FOLLOWING AS ATTACHMENTS:

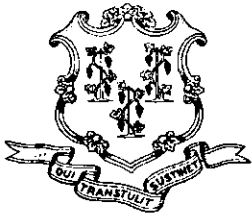
- [] 1. A copy of the applicant's articles of incorporation, or articles of organization, including all amendments.**
- [] 2. A copy of the applicant's bylaws.**
- [] 3. Certificates from the Secretary of State affirming that the MDP and its controlling company or organization (if applicable) is in good standing in the state. For out of state MDPs, controlling companies or organizations, a certificate that such MDP, controlling company or organization is in good standing in its state of organization.**
- [] 4. A list of the names, addresses, official positions of the individuals who are responsible for conducting the applicant MDP's affairs, including, but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing committee, the officers, contracted management company personnel, and any person or entity owning or having the right to acquire ten per cent or more of the voting securities of the applicant. This list shall fully disclose the extent and nature of any contracts or arrangements between the applicant and any individual who is responsible for conducting the applicant's affairs, including any possible conflicts of interest.**
- [] 5. Biographical affidavits on the form provided for each person listed above.**
- [] 6. A statement generally describing the applicant, its personnel and the health care services offered at a discount.**
- [] 7. A copy of the form of all contracts made or to be made between the applicant and any providers or provider networks regarding the provision of discount health care services to members.**
- [] 8. A copy of the form of any contract made or to be made between the applicant and the individuals listed in item 4 above.**
- [] 9. A copy of the form of any contract made or to be made between the applicant and any person for the performance on the applicant's behalf of any function, including, but not limited to, marketing, administration, enrollment, and subcontracting for the provision of health care services to members.**
- [] 10. A copy of the applicant's most recent financial statements audited by an independent certified public accountant, or, in the case of an applicant that is a subsidiary of a person or parent corporation that prepares audited financial statements reflecting the consolidated operations of the person or parent**



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corporation, a copy of the person's or parent corporation's most recent financial statements audited by an independent certified public accountant , provided the person or parent company also issues a written guarantee that the minimum capital requirements of the applicant required will be met.

- [] 11. A description of the proposed method of marketing.**
- [] 12. A description of the subscriber complaint procedures to be established and maintained.**
- [] 13. The Internet website address of the MPD which includes the up-to-date list of the names and addresses of the providers with which it has contracted.**



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OFFICER OR AUTHORIZED REPRESENTATIVE CERTIFICATION OF ACCURACY

I, _____, _____ of
(Printed Name) (Title)
_____, hereby certify that
(Medical Discount Plan)

I have reviewed the information submitted in accordance with Public Act 05-237, and that the information is true and accurate. I understand that at least thirty (30) days advance written notice of any change in the medical discount organization's name, address, principal business address or mailing address must be provided to the Insurance Commissioner. I hereby certify that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

(Signature of Officer or Authorized Representative)

(Date)

State of _____ County of _____

The foregoing instrument was acknowledged before me this _____ day of _____,

20____ By _____, and:

☐ who is personally known to me, or

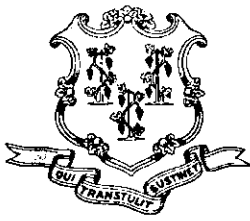
☐ who produced the following identification: _____

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires



State of Connecticut Medical Discount Plan (MDP) License Application

BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

(Print or Type)

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. a. Affiant's Full Name (Initials Not Acceptable). _____
b. Maiden Name (if applicable). _____
2. a. Have you ever had your name changed? _____ If yes, give the reason for the change and provide the full name(s).

b. Other names used at any time (including aliases).

3. a. Are you a citizen of the United States?
b. Are you a citizen of any other country, if so, what country?
4. Affiant's Occupation or Profession. _____
5. Affiant's business address. _____
Business telephone. _____
6. Education and Training:

<u>College/ University</u>	<u>City/ State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>
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<u>Graduate Studies:</u>	<u>College/ University</u>	<u>City/ State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree Obtained</u>
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<u>Other Training: Name</u>	<u>City/ State</u>	<u>Dates Attended (MM/YY)</u>	<u>Degree/Certification Obtained</u>
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(Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number in the space provided in the Biographical Affidavit Supplemental Information.)



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7. List of memberships in professional societies and associations.

<u>Name of Society/Association</u>	<u>Contact Name</u>	<u>Address of Society/Association</u>	<u>Telephone Number of Society/Association</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

8. Present or proposed position with the applicant entity. _____

9. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years.

Beginning/Ending
Dates (MM/YY) _____ - _____ Employers' Name _____

Address _____ City _____ State/Province _____

Country _____ Postal Code _____ Phone _____ Offices/Positions Held _____

Supervisor / Contact _____

Beginning/Ending
Dates (MM/YY) _____ - _____ Employers' Name _____

Address _____ City _____ State/Province _____

Country _____ Postal Code _____ Phone _____ Offices/Positions Held _____

Supervisor / Contact _____

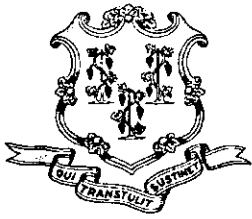
Beginning/Ending
Dates (MM/YY) _____ - _____ Employers' Name _____

Address _____ City _____ State/Province _____

Country _____ Postal Code _____ Phone _____ Offices/Positions Held _____

Supervisor / Contact _____

10. a. Have you ever been in a position which required a fidelity bond? _____ If any claims were made on the bond, give details. _____



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- b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked? If yes, give details. _____

11. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. Attach additional pages if the space provided is insufficient.

Organization/Issuer of License _____ Address _____

City _____ State/Province _____ Country _____ Postal Code _____

License Type _____ License # _____ Date Issued (MM/YY) _____

Date Expired (MM/YY) _____ Reason for Termination _____

Non-insurance Regulatory Phone Number (if known) _____

Organization /Issuer of License _____ Address _____

City _____ State/Province _____ Country _____ Postal Code _____

License Type _____ License # _____ Date Issued (MM/YY) _____

Date Expired (MM/YY) _____ Reason for Termination _____

Non-insurance Regulatory Phone Number (if known) _____

12. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

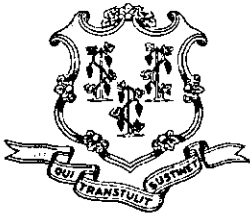
- a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency? _____

- b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action? _____

- c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action? _____

- d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses? _____

- e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses? _____



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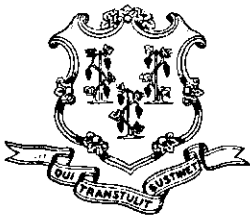
- f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses? _____
- g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking? _____
- h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute? _____
- i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government? _____
- j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity? _____

If the response to any question above is answered "Yes", please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

13. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. _____

If any of the stock is pledged or hypothecated in any way, give details. _____

14. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified. If the answer is "Yes", please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities. _____



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If any of the shares of stock are pledged or hypothecated in any way, give details.

15. Have you ever been adjudged a bankrupt? _____ If yes, provide details _____

16. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity? If yes, please indicate and give details. When responding to questions (b) and (c) affiant should also include any events within twelve (12) months after his or her departure from the entity.

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or Governmental-licensing agency? _____

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)? _____

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action? _____

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this _____ day of _____ 20__ at _____ I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

(Signature of Affiant)

Date

State of _____ County of _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20____ By _____, and:

☐ who is personally known to me, or

☐ who produced the following identification: _____

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires



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BIOGRAPHICAL AFFIDAVIT Supplemental Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

Full Name, Address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

1. a. Affiant's Full Name (Initials Not Acceptable). _____
b. Maiden Name (if applicable) _____
2. Affiant's Social Security Number _____
3. Government Identification Number if not a U.S. Citizen _____
4. Foreign Student ID# (if applicable) _____
5. Date of Birth: (MM/DD/YY) _____ Place of Birth: City _____
State/Province _____ Country _____
6. Name of Affiant's Spouse (if applicable) _____
7. List your residences for the last ten (10) years starting with your current address, giving:

Beginning/Ending

Dates (MM/YY)	Address	City	State/ Province	Country	Postal Code
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State of Connecticut Medical Discount Plan (MDP) License Application

Dated and signed this _____ day of _____, 20____ at _____ I hereby
certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and
correct to the best of my knowledge and belief.

(Signature of Affiant)

Date

State of _____ County of _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20____ By
_____, and:

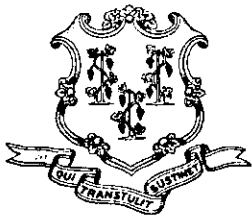
- ☐ who is personally known to me, or
- ☐ who produced the following identification: _____

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires



State of Connecticut Medical Discount Plan (MDP) License Application

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of _____[insert company name]("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both)("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact _____[insert company's designated person, position, or department, address and phone].

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) twelve (12) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

(Printed Full Name and Residence Address)

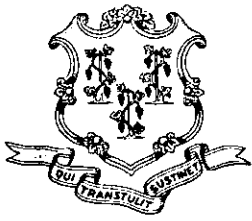
(Signature)

(Date)

State of _____ County of _____

The foregoing instrument was acknowledged before me this _____ day of _____ 20____ By _____, and _____.

☐ who is personally known to me, or



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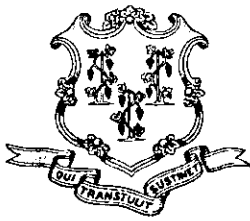
☐ who produced the following identification: _____

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires



State of Connecticut Medical Discount Plan (MDP) License Application

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS *(Minnesota and Oklahoma)*

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of _____[insert company name] ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may request more information about the nature and scope of Background Reports produced by any consumer reporting agency ("CRA") by submitting a written request to Company. You should submit any such written request for more information, to _____[insert company's designated person, position, or department, address and phone].

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act." You will be provided with a copy of any Background Report procured by Company if you check the box below.

- ☐ By checking this box, I request a copy of any Background Report from any CRA retained by Company, at no extra charge.

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) twelve (12) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

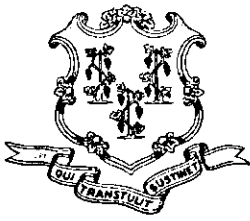
(Printed Full Name and Residence Address)

(Signature)

(Date)

State of _____ County of _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20____ By _____, and _____



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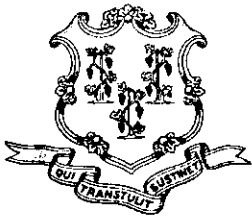
- ☐ who is personally known to me, or
☐ who produced the following identification: _____

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires



State of Connecticut Medical Discount Plan (MDP) License Application

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS (*California*)

This Disclosure and Authorization is provided to you in connection with a pending application of _____ **[insert company name]** ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) ("Background Reports") regarding your background for review by any department of insurance in such states where Company is currently pursuing an Application, because you are either functioning as, or are seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports will be obtained through _____ **[insert name of CRA, address]** ("CRA"). Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may request more information about the nature and scope of Background Reports produced by any consumer reporting agency ("CRA") by submitting a written request to Company. You should submit any such written request for more information, to _____ **[insert company's designated person, position, or department, address and phone]**.

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act." You will be provided with a copy of any Background Report procured by Company if you check the box below.

- ☐ By checking this box, I request a copy of any Background Report from any CRA retained by Company, at no extra charge.

Under section 1786.22 of the California Civil Code, you may view the file maintained on you by the CRA listed above. You may also obtain a copy of this file, upon submitting proper identification and paying the costs of duplication services, by appearing at the CRA in person or by mail; you may also receive a summary of the file by telephone. The CRA is required to have personnel available to explain your file to you and the CRA must explain to you any coded information appearing in your file. If you appear in person, you may be accompanied by one other person of your choosing, provided that person furnishes proper identification.

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. In no event, however, will this authorization remain in effect beyond twelve (12) months following the date of my signature below.



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A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

(Printed Full Name and Residence Address)

(Signature)

(Date)

State of _____ County of _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20____ By _____, and

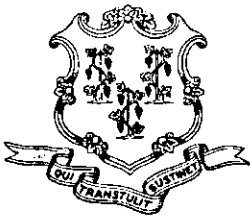
- ☐ who is personally known to me, or
☐ who produced the following identification: _____

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires



State of Connecticut Medical Discount Plan (MDP) License Application

SAMPLE BOND FORM STATE OF CONNECTICUT MEDICAL DISCOUNT PLAN (MDP) BOND

KNOW ALL MEN BY THESE PRESENTS

That we, _____ of the
(Name of MDP)

County of _____ State of _____

as Principal, and _____, a surety

company having its principal place of business in _____

County of _____ State of _____ duly authorized to
do business in the State of Connecticut, as Surety, are held and firmly bound unto the member/providers of
the MEDICAL DISCOUNT PLAN (MDP) named, as Obligees, in the sum of

_____ dollars (\$_____) for the payment of
which sum the said Principal and Surety do jointly and severally bind themselves, their heirs, executors,
administrators, successors, and assigns, and each and every one of them firmly by these presents.

THE CONDITION OF THIS OBLIGATION IS SUCH THAT WHEREAS, the Principal has
made application to the Insurance Commissioner of the State of Connecticut for a license to engage in the
business of a Medical Discount Plan (MDP) in accordance with the provisions of Public Act 05-237 and any
regulation promulgated thereunder. This surety is intended for the sole purpose of meeting the obligation as
described in Section 2(j) of P.A.05-237: "Each medical discount Plan organization shall at all times (1)
maintain a net worth of at least two hundred fifty thousand dollars, or (2) posted a surety bond in the amount
of one hundred thousand dollars."

PROVIDED HOWEVER, that all obligations upon this bond shall cease upon the voluntary or
involuntary termination of such license except as to such liability as shall have been accrued thereto.

IN WITNESS WHEREOF, the said Principal and Surety have signed and sealed this instrument this

_____ day of _____ 20_____.

WITNESS

(As to Principal)

By _____ L.S.
_____ L.S.

(As to Surety)

By _____ L.S. Corporate Seal
_____ L.S.